Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
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DIVISION OF MEDICAL QUALITY

Embassy Suites
Santa Ana, CA

May 12, 2006

MINUTES

Agenda Item 1
A quorum was present and due notice having been mailed to all interested parties, the meeting was called to order at 8:03 a.m. Members present included:

Members Present:
Ronald L. Moy, M.D., President
Martin R. Greenberg, Ph.D., Secretary
Steve Alexander
William S. Breall, M.D.
Stephen R. Corday, M.D.
Shelton Duruisseau, Ph.D.
Mary L. Moran, M.D.
Lorie G. Rice
Ronald H. Wender, M.D.
Barbara Yaroslavsky

Members Absent:
Cesar A. Aristeiguieta, M.D., Vice President
Catherine T. Campisi, Ph.D.

Staff and Guests Present
David T. Thornton, Executive Director
Kimberly Kirchmeyer, Deputy Director
Renee Threadgill, Interim Chief of Enforcement
Ana Facio, Deputy Chief
Anita Scuri, DCA Legal Counsel
Laura Freedman Edison, DCA Legal Counsel
Carlos Ramirez, Senior Assistant Attorney General
Sanford H. Feldman, Deputy Attorney General
Candis Cohen, Public Information Officer

Linda Whitney, Chief of Legislation
Kevin Schunke, Regulation Coordinator
Letitia Robinson, Legislative Analyst
Frank Valine, Diversion Program Manager
Richard Prouty, Staff Services Manager
Valerie Moore, Associate Governmental Program Analyst
Arlene Krysinski, Associate Governmental Program Analyst
Teresa Schaeffer, Associate Governmental Program Analyst
Laura Sweet, Area Supervisor
Lynda Swenson, Area Supervisor
Glenda Finley, Supervising Investigator
John Hirai, Supervising Investigator
James Kovash, Supervising Investigator
Kathleen Nicholls, Supervising Investigator
Tamara Jazaie, Senior Investigator
Steven Rhoten, Senior Investigator
Paul Ramirez, Investigator
Julie D'Angelo Fellmeth, Center for Public Interest Law
Sandra Bressler, California Medical Association
Brett Michelin, California Medical Association
Richard Frankenstein, M.D., California Medical Association
Zennie Coughlin
James Futrell, M.D.
William A. Norcross, M.D., Director, Physician Assessment and Clinical Education Program
Zack L. Moore, M.D.
Aysun Alagoz, M.D.

Agenda Item 2 Approval of Orders

Approval of Orders Restoring License Following Completion of Probation
The Division reviewed and approved 9 Orders. Vote: 10-0

Approval of Orders Issuing Public Letters of Reprimand
The Division reviewed and approved 12 Orders. Vote 10-0

Approval of Orders for License Surrender During Probation/Administrative Action
The Division reviewed and approved 2 Orders. Vote 10-0

Agenda Item 3 Approval of Minutes

It was M/S (Alexander/Rice) to approve the Open Session minutes of the February 3, 2006 Division Meeting. Motion carried (10-0).

Agenda Item 4 Legislation and Pending Regulations

No report was given.

Agenda Item 5 Diversion Program Report

Frank Valine, Diversion Program Administrator, gave a brief overview of the Diversion Committee's meeting held on May 11, 2006. He stated staffing issues were discussed and options to fill vacant positions were presented. He stated the Diversion Evaluation Committee and Group Facilitators held meetings to discuss the programmatic problems identified by the Enforcement Monitor's Recommendations. A subcommittee was formed to provide options for solutions, and the proposed solutions were presented to the Diversion Committee at its meeting on May 11, 2006. Mr. Valine stated the Medical Board/Diversion Committee is now an active member of the Federation of State Physician Health Programs. He attended the meeting held in Boston in conjunction with the Federation of State Medical Boards. The meeting next year will be held in San Francisco. Mr. Valine stated Quarterly Group Review Reports, statistics from the Collection System Manager's report and a new financial status report pursuant to SB231 were presented to the Diversion Committee. He stated the recommended audit by the Bureau of State Audits was approved by the Joint Legislative Audit Committee. The audit, which is approximately a four-month long process, will start around November/December 2006. He anticipates the results of the audit will be received around June 2007. Mr. Valine stated a work group is being formed to develop a Diversion Advisory Committee. He further stated Julie D'Angelo Fellmeth presented ideas, options and information on work-site and hospital monitor issues.

Dr. Wender congratulated Mr. Valine on doing an outstanding job of correcting many of the problems found by the Enforcement Monitor.

Agenda Item 6 Vertical Prosecution Update

Carlos Ramirez, Senior Assistant Attorney General, and Renee Threadgill, Interim Chief of Enforcement, reported on vertical prosecution. Mr. Ramirez stated since the last meeting, he and Ms. Threadgill met several times and discussed the changes in the programs. He stated the two most important mandates contained in SB231 were the transfer of the responsibilities for investigating medical board cases to the attorney general's office and the vertical prosecution of cases involving discipline of physicians. He stated all of the cases referred for investigation after January 1, 2006, are in the vertical prosecution model. However, the existing cases, those referred to the Medical Board for investigation prior to January 2006, are in various stages of processing, i.e., waiting for referral to an expert for an expert opinion, waiting for the expert's opinion or waiting for assignment to a DAG. Mr. Ramirez stated the small sample of data collected so far, although not considered reliable at this point, is positive.

Dr. Wender asked Mr. Ramirez whether there was any particular process being done differently which could be attributed to being able to obtain the higher rate of ISOs this year than from past years. Mr. Ramirez stated two things may be responsible for the recent success in obtaining ISOs. The first may be due to earlier identification of ISO cases than in the past. The second may be a result of a greater efficiency in the gathering and presentation of the evidence.

Ms. Threadgill stated the use of the Investigative Plan and Progress Report (IPPR) has been implemented. She stated the IPPR provides the Deputy Attorney General assigned to a case with

a synopsis of the complaint and the steps the investigator plans to take. She stated Consumer Affairs System's (CAS) codes have been identified to capture data to be used to evaluate the steps of the vertical prosecution model. She stated the CAS codes help identify, among other things, how long it takes to complete various tasks during the investigation and causes for investigation delays and case resolution. A new report format has been implemented to provide incremental updates to the DAG as the case unfolds. Ms. Threadgill stated she and Mr. Ramirez have been in discussion regarding the development of an operation procedure manual, which will be an invaluable training tool for new investigators and new DAGs joining the vertical prosecution team. She stated assistance from outside resources will be utilized in developing the joint procedure manual.

Ms. Threadgill reported MBC supervisors and investigators are adjusting to the new relationship with the AG's office and appear to be pleased with the new communication they are developing with the prosecutors. She stated of the 93 sworn positions, the Board currently has 10 vacancies with notifications from 10 others, who are planning to leave due to retirement, extended leaves, and/or transfers to other agencies. She stated the remaining dedicated staff have performed outstandingly during the first quarter of this pilot.

Ms. Threadgill stated from January 1, 2006 to date, there have been 424 cases referred for investigation and are in the vertical prosecution model. She provided examples of two recent situations where resolution was achieved in a most expeditious manner. She stated the quicker resolutions resulted from the new, closer working relationship with prosecutors. She stated the lead prosecutors in the Los Angeles area offices have been particularly helpful and saved a lot of time with subpoena enforcement by explaining the Board's entitlement to peer review documents to counsel at hospitals. Earlier involvement by a prosecutor has resulted in faster filings of actions where there has been a failure of PACE and where there is substantial risk to the public.

Dr. Wender stated he was pleased with the way the integration was going. He asked Ms. Threadgill whether steps have been taken to possibly avert a potential manpower crunch and improve or speed up the recruiting efforts. Ms. Threadgill stated she and Ana Facio, Deputy Chief, have been in discussion with the Department of Consumer Affairs examination unit in regard to developing more frequent or at least consistent examinations in those job classes where the Board has experienced difficulty in recruiting. She stated in order to hire persons for civil service positions, they would first need to successfully complete an examination and be placed on a civil service employment list. Discussion ensued in regard to the possible options for staff recruitment and retention. Mr. Alexander stated Ms. Threadgill and Mr. Ramirez need to present the DMQ with a comprehensive plan to address and solve the anticipated crisis by the next meeting. Ms. Rice added the comprehensive plan would need to include staff recruitment and retention plans for the next five years. Dr. Wender and Ms. Yaroslavsky volunteered to meet with Ms. Threadgill and Mr. Thornton to discuss and review the available options for filling civil service positions.

Agenda Item 6B Medical Expert Program – Survey

Ms. Threadgill reported the Board continues to receive positive feedback regarding the

interaction between investigative staff and the expert reviewers. She stated 9 of the 28 surveys received specifically commented on their positive experiences. She stated the feedback process is being expanded to include information received from the DAGs evaluation form regarding the expert's report and testimony. She stated shortages in certain specialty areas still exist, as the Board is in need of neurological surgeons who specialize in the spine, interventional cardiologists, radiologists and vascular surgeons. Dr. Breall stated the pay scale for the experts in these specialty areas is not optimal considering the Board only pays the experts $100 an hour and they make $400 - $600 an hour in the private sector. Dr. Wender stated although recruitment of these specialty experts cannot be based on the benefits or the pay scale, there are quite a few very qualified physicians who are experts because they think of it as providing a community service. He suggested a request for those specialty experts be sent to each Board member. Discussion ensued on whether incentives, i.e., certificates, CME credits, etc., could be offered to attract physicians in these specialty areas to become experts.

Sandra Bressler, California Medical Association, stated the Board should regularly look at the frequency of use of its experts to make sure the same experts are not being used over and over again. Dr. Wender stated the Board has looked at the use of the experts and spent a lot of effort on making sure this does not occur. Ms. Threadgill stated the Board has a system in place to ensure the experts are not over utilized. She stated the Board has developed a new way of tracking the number of reports and expert usage. When the expert reaches a threshold number, they are no longer able to be used. Dr. Wender stated a report on the usage of experts has been prepared and a copy would be provided to Ms. Bressler for review.

Agenda Item 7 Presentation on New Form of Peer Review

Dr. Wender introduced James Futrell, M.D., of the Society of Quality Medicine, who provided a detailed presentation of a new approach to peer review which would be available to hospitals, physicians, etc. Dr. Futrell stated he has been involved with the Board as a consultant for a number of years. He stated he and other physicians have been levying for several years for a new peer review concept designed to try to reduce the problems of increasing medical malpractice premiums. Dr. Futrell stated the medical expert is a central part of medical malpractice. In any tort, the medical expert must be willing to sign a declaration or otherwise assert there has been breach of some standard of care relative to the medical care to a patient. The medical expert must define the breach of the physician's duty and then relate the breach to the injuries the patient sustained. The court then must recognize the declaration or assertion by a physician for the tort to be successful. Dr. Futrell stated the statements seen in the press regarding frivolous lawsuits and instances of inappropriate defense of physicians cannot occur but for the statements of a medical expert. He stated it is most appropriate to look into the management of all 24 specialties to make sure expert medical consultants are properly representing the standards of care and appropriately noting breaches of those standards of care consistently as with the mandates, teachings, and knowledge associated with the information coming from the national medical specialty organizations. Dr. Futrell stated this new peer review concept was given at the American College of Legal Medicine a couple of months ago. He stated the American College of Legal Medicine is an educational organization composed of physicians who are also lawyers and are very active in the law primarily on the defensive budget side in medical malpractice litigation. He stated the concept was also presented to the CMA a few days ago. He stated he is a member of the Protecting Liability Committee of the CMA. He stated the Expert Medical

Consultants organization is seeking support of organizations who have a specific and critical interest in how medical experts operate and want to assure they are providing the proper services, irrespective of a tax upon insurance companies.

Dr. Futrell stated there are a few organizations actively involved in peer review committees trying to get a handle on what their experts are doing. He stated the American Association of Neurological Surgeons has a very important case, wherein a physician was disciplined for testimony deemed to be egregious, which resulted in some very extensive legal entanglements. He stated although the physician was appropriately censured, the medical specialty organizations noted the cost of the litigation on the medical specialty organization was exorbitant. He stated from a legal standpoint, the case had a chilling effect on doing anything with experts by the national specialty organizations. Dr. Futrell stated the specialty organizations are very amiss in terms of exactly defining their standards of care. He stated the specialty organizations post practice parameters and other documents on their Web sites, however, they do not post a list of their standards or anything related specifically to the standards of care. He stated the reason is those particular documents can be used inappropriately by a plaintiff to the detriment of a defense physician, if not exactly pertinent to the circumstance in a particular case. Dr. Futrell stated the real standards of care for all the specialties are defined by the statements made by the expert consultant in the case. He stated cumulative expert medical consulting work and testimony is being collated and put into databases on both the plaintiff and defense sides. He stated expert medical consultants, who are under no specific control by their own specialty organizations, are defining the standard of care. He added inappropriate testimony is tainting the database and can be used to the detriment of the profession, physician, patient and/or the plaintiff, who may have a legitimate case. He stated the Institute of Medicine stated there are about 100,000 cases a year where errors have been made and where some have litigation as a reasonable relief possibility for the patient.

Dr. Futrell stated the Expert Medical Consultants is a voluntary organization and through the association and support of organizations such as the MBC, CMA and other organizations, they intend to create a public image which is appropriate for expert medical consultants to belong. He stated medical expert consultants would want to belong to this new organization because it holds experts making defensible statements in torts and medical malpractice cases, and having such statements available for review by well-recognized experts in their own specialty as to the consistency of statements relative to the standards of care. Dr. Futrell stated the organization will have a very close coordination with all of the medical specialty committees and national specialty organizations within the Expert Medical Consultants organization in order to keep abreast of changes and new ideas for particular procedures. He stated more details and further consultations with appropriate administrative personnel within the organization to outline the bylaws, rules and regulations will occur at subsequent meetings. He stated the Board will have a chance to look at this new review process in more depth and be assured the Expert Medical Consultants is an organization the Board can support. Dr. Futrell stated the Expert Medical Consultants' Web site will be on-line in a few weeks.

Dr. Breall asked Dr. Futrell how cases are called to the attention of the Expert Medical Consultants. Dr. Futrell stated a case can be reviewed when the organization receives notification from a specialty organization of a complaint or simply because the expert is a

member of the Expert Medical Consultants and thereby subject to a random review of cases.

Dr. Wender stated the whole area of expert testimony is a disaster because anyone with a MD degree can be an expert. He stated some expert testimony is given because of financial gain and does not reflect the standard of care. He stated experts for the defense do everything they can to fight against accurate, fair plaintiff expert testimony, making it difficult for patients to receive a fair resolution of their case. Dr. Wender stated, in the past year, the Board disciplined a medical expert based on his or her medical expert testimony.

Dr. Corday asked Dr. Futrell what will be the Expert Medical Consultants' final result, e.g., a standard of care statement, a list of physicians and how the organization grades them or a list of all physicians who have ever given expert testimony in the United States. Dr. Futrell stated the Expert Medical Consultants plan to introduce a core educational component to the medical consultant process because there are no educational requirements for experts with the exception of board certification. He stated the organization will evaluate many of the experts' testimonies rather than simply looking at one case and deciding right or wrong. He stated the organization plans to have at least five to ten nationally recognized, board-certified experts, who are very active in their own national specialty, watch the specialty committees to ensure their opinions will not only be appropriate, but are respected by everyone across the nation. Dr. Futrell thanked the Board for allowing him to make the presentation and stated he will send the Board a follow-up letter outlining the process.

Agenda Item 8 Discussion on Practice Monitoring Condition

Dr. Moy stated the practice monitoring condition and the surgical deficiencies program are overlapping topics. He stated Ms. Rice and Ms. Facio will discuss the practice monitoring condition, Sandy Feldman will discuss the surgical deficiencies program and Dr. Norcross will review some of the existing programs throughout the country.

Ms. Rice stated the DMQ has been very concerned about the issue of the practice monitor. She stated some of the members of the DMQ had the impression practice monitoring meant something with more accountability than what was actually transpiring. She stated in reviewing the practice monitor model, the task force found there was no consistency in payment to the practice monitor, the oversight of the physician being monitored was too infrequent, and the oversight of the physician was primarily on paper, i.e., looking at the physicians' records. She stated the DMQ envisioned the practice monitor would actually see interaction between the physician and the patient. Ms. Rice stated the information presented today will provide the DMQ with possible solutions, and a more protracted and detailed proposal will be presented to the DMQ at the next meeting.

Ms. Facio stated in 2003, the Board revised the Disciplinary Guidelines and made a number of enhancements to the practice monitoring condition. She stated language was added to allow probationers to complete the PACE Professional Enhancement Program (PEP) as alternatives to having practice monitors, however, the PEP was not operational until July 2004. She stated since its inception, Dr. Norcross has taken 16 probationers into the PEP Program.

Ms. Swenson stated since the last Board meeting, surveys were sent to the 126 active practice

monitors within the probation unit. She provided a brief overview of some of the questions asked of the practice monitors and the responses received from 52 of them. She asked what experiences prepared them for being practice monitors, 14 responded their resident fellowship and medical school teaching, 15 responded proctoring, 22 stated service on peer review committees, one stated service as an expert witness and several indicated they hold Chief of Staff positions. She stated the practice monitors were also asked about the fees charged to the physician for their services. She stated the surprising statistic was 59 percent, i.e., 30 of the 52 the practice monitors, responded they do not charge for their services, however, the other responses varied greatly and more work is needed to convert the charges to an annual rate. Ms. Rice stated while not charging for their services may appear to be a positive and could be construed as the practice monitors are exhibiting a professional response to the issue, however, there is a greater concern that there may be more familiarity between the practice monitors and the physicians. Ms. Swenson stated the practice monitors were asked about the amount of time spent doing various activities, i.e., chart reviews, writing reports, in-person meetings with the probationers, travel, etc. She stated the responses varied dramatically, ranging from 30 minutes to 35 hours per month. She stated some of the practice monitors indicated they spend a tremendous amount of time working with the probationers and are in more of proctoring situation. She stated the responses reflect the practice monitors travel anywhere from 15 minutes to three hours to meet with the probationers. Ms. Swenson stated several practice monitors stated they spent time researching various issues, i.e., mitigation type issues or research to support their position in requesting the probationer to make changes to their practices. She stated the responses from the practice monitors in regard to the question of whether they felt they should have a standardized tool for tort audits were quite even with 39 percent answering yes and 43 percent answering no. She stated the practice monitors were asked whether the Board should require them to attend a basic training course for practice monitoring. She stated 59 percent of them answered yes and 39 percent answered no. Ms. Swenson stated several of those who responded to the question suggested if a core course is developed, it should be a home study or on-line program, which could be used as a reference and provide ongoing information for future research. She stated the practice monitors were given the opportunity to provide recommendations for improvement of the program. She stated responses varied, e.g., having more hands on experiences in conducting patient evaluations for greater involvement with the patients, having set standards of practice monitoring, not having set standards, having the program be responsive to the needs of the practice monitors and the physicians, having limitations set on what they are supposed to do, when not to intervene, etc. Ms. Rice stated the task force plans to present a formal proposal to the DMQ at the next meeting.

Dr. Norcross presented the members of the DMQ with a manual containing the latest version of the "UCSD PACE Physician Enhancement Program and other Program Throughout the World." He stated the term "physician enhancement" is the American and Canadian term for any activity involving physician discipline, competency assessment and remediation. He stated the members of the DMQ should access some of the Web sites referenced in the manual for a better understanding of the program and information contained therein. Dr. Norcross stated he is the president of the Coalition for Physician Enhancement, which is the North American organization that brings together programs like PACE. He stated the Coalition for Physician Enhancement mostly consists of groups from Canada and the United States, but an increasing number of groups from Europe have joined. Dr. Norcross stated the New South Wales Medical Board,

directed by Dr. Allison Lee, does not appear in the manual, but is an outstanding program. He stated he has received more ideas and assistance from Dr. Lee than from any of the programs included in the manual. He stated the PEP program is a composition of all the information received from these groups. He stated the tools for the PEP program are considered by PACE to be in the public domain and will eventually be put on the PACE Program's Web site in PDF format for use by anyone wanting to serve as a monitor. He stated the goal is to have some general consistencies in the instruments, tools, mechanisms and methodologies used throughout California, possibly the United States.

Mr. Feldman stated Dr. Norcross is currently assisting the Board in the development of a surgical proctoring guideline for cases involving surgical misadventures. He stated when a surgical concern occurs, the physician would be required to complete a two-day PACE assessment followed by a significant evaluation of the physician's practice including an on-site visit of the physician's office; chart reviews; interviews with staff members, peers and anyone who might have some relevant information about the physician; and actual observation or proctoring of surgical cases to ensure the physician was competent to perform the procedure. He stated additional assessments would be conducted on an ongoing basis and would culminate with a second set of proctoring and chart review occurring 13 months after the initial evaluation. Mr. Feldman stated the reviewer would advise the Board whether the physician had improved and was competent and safe to practice. He stated more time is needed to prepare the surgical guideline.

Mr. Feldman stated Dr. Moy and Ms. Rice, DMQ practice monitor task force members, asked him to draft language for expectations of a practice monitor. He stated he has drafted some language which incorporates much of the same language of the surgical guideline. He stated the practice monitor would be expected to conduct a thorough assessment of the physician's practice, including inspection of the premises, i.e., equipment and instruments, billing review, compliance with OSHA check, compliance with CLEA check, physician's hospital privileges, compliance with CMA, malpractice actions filed, extensive chart reviews, and interviews with staff members, peers, and others. Mr. Feldman stated the ideal monitoring concept is to have physicians monitored by monitors who have attended and successfully completed a board-approved training program and to have standard reporting documents, which includes chart audit tools, etc.

Dr. Moy stated the Board obviously has a need to improve the existing practice monitoring system. He stated there is also a need for further evaluation of physicians who have surgical deficiencies. He stated a committee consisting of Ms. Rice, Dr. Greenberg and himself would now need to hold public meetings to discuss the specifics of the programs.

It was M/S (Rice/Yaroslavsky) for the practice monitoring committee to hold a meeting within the next month to discuss movement of the issue of practice monitor and surgical review process. The motion carried unanimously.

Agenda Item 9 Election of 2006/2007 Officers

Dr. Moy asked for nominations for the position of President. Dr. Greenberg nominated Dr. Aristeiguieta and Mr. Alexander seconded the motion. There being no other nominations, Dr.

Aristeiguieta was elected President of the Division of Medical Quality by acclamation.

Dr. Moy asked for nominations for the position of Vice President. Dr. Wender nominated Dr. Greenberg and Ms. Rice seconded the motion. There being no other nominations, Dr. Greenberg was elected Vice President of the Division of Medical Quality by acclamation.

Dr. Moy asked for nominations for the position of Secretary. Dr. Wender nominated Ms. Yaroslavsky and Ms. Rice seconded the motion. There being no other nominations, Ms. Yaroslavsky was elected Secretary of the Division of Medical Quality by acclamation.

Agenda Item 10 Agenda Items for July 2006 Division Meeting

Overall Plan for Recruitment and Retention of Staff and Specialty Experts

Discussion of Practice Monitor

Agenda Item 11 Public Comment

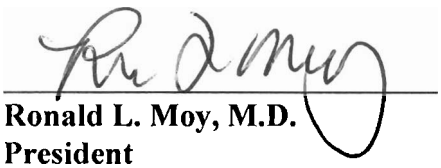
Aysun Alagoz, M.D. stated she is an OB/GYN, who has been practicing in a small town near San Antonio, Texas for the past four years. She stated she practiced in the San Francisco Bay Area for six years prior to moving to Texas, but she maintains an active California license. Dr. Alagoz stated the Board filed an accusation charging her with violations of the Business and Professions Code, including repeated negligent acts, for a single patient case with uterine rupture and fetal demise. She stated in May of 2001, she had a patient who desired a vaginal birth after cesarean for the second pregnancy. She stated a vaginal birth after cesarean has a known risk of uterine rupture of approximately 1 percent, and can result in excessive bleeding, hysterectomy, fetal demise and even maternal death. She stated this particular delivery did have a uterine rupture with a fetal demise. Dr. Alagoz stated she was sued for the delivery and for various reasons, including her health, she moved to Texas and chose not to defend the lawsuit. She stated six months later, she received a letter from an investigator of the Board regarding the case and asking her to attend an optional, in-person meeting with the investigator. She stated she elected not to attend the in-person meeting with the investigator, as she had just started working in Texas. She stated six months later, she received a letter from the Board stating the investigators found some serious problems with her management of the patient. She stated she was offered a public letter of reprimand and would be required to complete the PACE Program. Dr. Alagoz stated in contrast, she received a letter from the HMO, which the patient was under, stating they reviewed her management of the case and had no issues with it, was never called to peer review at the hospital and did not have her hospital privileges curtailed in anyway. She stated she declined the offer of the reprimand, which resulted in the accusation being filed against her. She stated she believed the accusation to be without merit and after obtaining two experts, who refuted the Board's opinion, and after presenting the case at a settlement conference, the Board withdrew its accusation. Dr. Alagoz stated the matter cost $45,000 to resolve, lasted more than five years and the whole process devastated her career and practice in the interim. She stated bad outcomes will continue to happen in high-risk specialties and it is incumbent upon the Board to exercise extreme caution in single patient care issues.

Ms. Bressler expressed concerns about the case of Dr. Alagoz. She stated a number of years ago, CMA received reports of accusations alleging repeated negligent acts in single incident cases were filed against physicians by dividing the case up into little pieces and asserting each little

piece was a separate negligent act. She stated after an enormous amount of research, a sufficient number of examples where found and the matter was presented to the Legislature. Legislation was passed to make it illegal and the Board was not to prosecute repeated negligent acts in single instances by simply breaking up those instances into little pieces. Ms. Bressler stated she was concerned this case may represent a resurgent of that practice. She recommended the Board review this case to ensure it was not and to determine if there is something the Board can do to prevent the same situation from happening in the future. Dr. Wender stated he would review the case.

Mr. Feldman, DAG, stated while he was not familiar with this particular case, he heard the physician indicate there were three extreme departures from the standard of care found by the expert. He stated this is clearly not an indication or an instance of splitting up a single simple departure into multiple departures. He stated the amendment of the statute made it clear simple departures had to be unrelated even if they were during a single patient visit. He stated if a physician misdiagnoses a patient and then gives the patient the wrong medication for the misdiagnosis, there might be two separate and distinct simple departures. Mr. Feldman stated he was not aware of an instance of splitting matters up in order to file an accusation. He stated there is absolutely no interest on the part of the DAGs or the Board's investigators to file an accusation for filing sake, as they have way too much work to do. He stated accusations filed after an expert opinion is received are filed in good faith, but there is always an opportunity for the physician to provide opposing expert opinions to be reviewed during the process. He stated with the implementation of the vertical prosecution model, there is earlier attorney involvement. Mr. Feldman stated he has seen cases where an expert opinion came in and the expert's issues were addressed by the physician during the in-person interview. He stated all information is reviewed and the AG's office is happy to withdraw an accusation if there has been a mistake.

Agenda Item 12 Adjournment
There being no further business, the meeting was adjourned at 10:37 a.m.



Ronald L. Moy, M.D.
President